IN THE CORONER'S COURT OF VICTORIA AT MELBOURNE

CASE No. 4248/12

IN THE MATTER OF AN:

INQUEST INTO THE DEATH OF LILY IRWIN

RESPONSE OF EASTERN HEALTH TO CORONER'S RECOMMENDATIONS PURSUANT TO SECTION 72(2) *Coroners Act 2008*

1. Recommendation Three: **That Eastern Health consider using the death of baby Lily (de-identified) as a case example to its staff to highlight the importance of safe practice and maintaining professional boundaries.**

1.1 Eastern Health agrees that the case of baby Lily would be a useful case study to utilise as a tool in the training and professional development of Eastern Health employees to highlight important issues regarding professional conduct and safe practice in the provision of midwifery care and medical treatment of patients.

1.2 Eastern Health utilised the case of baby Lily on a de-identified basis as a case example highlighting key issues of safe clinical practice during labour and delivery at an Eastern Health multi-disciplinary combined perinatal meeting which took place on 27 November 2014.

1.3 The meeting was attended by a significant number of midwifery and medical staff and supported by the attendance and contribution of senior Eastern Health officers including the chairperson of the Eastern Health Board, Dr Joanna Flynn. Dr Flynn contributed to the meeting in her role as Chair of the Medical Board of Australia.

1.4 Eastern Health will continue to review appropriate forums in which the case of baby Lily can be used as a case example in the training of Eastern Health staff on issues including the importance of safe practice and maintaining professional boundaries.

2. Recommendation Four: **That Eastern Health consider whether there is a need to establish protocols for the obstetric management of colleagues or friends.**

2.1 At the time of baby Lily's death, Eastern Health had in place a policy entitled "Providing Services to Employees' Relative, Friend or Acquaintance". The policy provided guidance to all Eastern Health clinicians in relation to the provision of health services to friends, relatives and acquaintances.

2.2 A copy of the current policy "Providing Services to Employees' Relative, Friend or Acquaintance" is submitted with this response and marked **Attachment A.**

2.3 Eastern Health is in the process of developing a new policy specifically dealing with the obstetric management of Eastern Health colleagues, friends and relatives.

2.4 Eastern Health is aware that whilst the Australian Health Practitioner Regulations Agency (**AHPRA**) Code of Conduct for registered Health Practitioners does not prohibit the provision of health services by a health practitioner to colleagues or relatives, it does prescribe "good practice" steps and conduct that should be adopted by a practitioner when providing care to a colleague and/or relative.

2.5 Eastern Health will have regard to the "good practice" guideline in the development of its new policy.

2.6 Eastern Health is also reviewing its current policy "The Role of the Support Person During Labour" which provides guidance to Eastern Health employees who act as support persons for women in labour.

2.7 A copy of the current policy "The Role of the Support Person During Labour" is submitted with this response and marked **Attachment B.**

3. <u>Recommendation Five:</u> **That the relevant Eastern Health policies be amended to explain the importance of prophylactic antibiotics, both in preventing infection and in treating subclinical infections.**

3.1 Eastern Health has amended its "Prelabour rupture of Membranes at Term" Practice Guideline which clarifies the importance of the administration of prophylactic antibiotics following the rupture of membranes, both in the prevention of infection and the treatment of subclinical infections.

3.2 A copy of the revised Practice Guideline "Prelabour Rupture of Membranes at Term" is submitted with this response and marked **Attachment C.**

4. <u>Recommendation Six:</u> **That Eastern Health's Expected Pathways of Care for Pregnant Women policy should be amended to explain what is required by way of 'assessment'.**

4.1 Eastern Health has reviewed the "Expected Pathways of Care for Pregnant Women" policy to include an explanation of what conduct Eastern Health requires a clinician to undertake in circumstances where the pathway recommends an "assessment" by a clinician.

4.2 The policy will be amended to include the following definition of an "assessment":

"the qualified opinion of a clinician during which time information is collected to identify the patient's needs and formulate a treatment plan. An assessment does not necessarily require the person making the assessment to personally examine the patient but often it will. It does require the assessor to be in possession of sufficient information to make an informed assessment."

5. <u>Recommendation Seven:</u> **That relevant Eastern Health policies should be amended to explain the reason why continual CTG monitoring is preferred**

over intermittent auscultation, in particular its greater capacity to detect reduced foetal heart rate variability.

5.1 Eastern Health accepts that CTG monitoring has a greater capacity to detect reduced foetal heart rate variability in comparison to intermittent doppler auscultation.

5.2 Eastern Health is currently reviewing its "Intrapartum Fetal Surveillance and CTG Interpretation and Fetal Scalp/Cord Blood Sampling" policy to ensure the policy clearly outlines in which circumstances continual CTG monitoring is preferred over intermittent auscultation including an explanation as to why CTG monitoring is the preferred monitoring option in such circumstances.

5.3 The revised policy will also confirm that Eastern Health adopts the relevant CTG monitoring guidelines recommended by the RANZCOG.

6. <u>Recommendation Eight</u>: **That the PROM policy should be amended to align with the already amended Water Immersion Policy to explain that bathing in the case of PROM possibly involves an increased risk of infection.**

6.1 Eastern Health has amended its "Prelabour Rupture of Membranes at Term" Practice Guideline to include that women should be informed that bathing may be associated with an increased risk of infection.

6.2 A copy of the revised Practice Guideline "Prelabour Rupture of Membranes at Term" is submitted with this response and marked **Attachment C.**

easternhealth

Providing Services to Employees Relative, Friend or Acquaintance.

Scope: Eastern Health	**Policy Number:** 94
Executive Sponsor: ED Nursing and Support Serv	**Approving Body:** EH Executive Committee
Policy Status: Revised	**Policy Developed:** 01-09-2005
Last Review Date: 14-08-2012	**Next Review Date:** 14-08-2015

Purpose:

To limit the potential for difficulties that could result from a staff member caring for a relative, friend or acquaintance and to ensure professional boundaries are maintained.

Details:

Rationale

The admission of a relative, friend or acquaintance of a staff member to inpatient care requires an approach that balances the welfare of staff and the well being of the patient and their family. This guideline has been developed on 2 premises:

1. All staff have the right to work in an environment that is not additionally complicated by the treatment of a relative, friend or acquaintance.
2. All patients regardless of their relationships have a right to appropriate treatment and care.
3. All clinical staff have an obligation to maintain professional boundaries when caring for patients.

Definitions

A relative, friend or known acquaintance is any person that the staff member knows to fit this definition.

Policy

Staff members are to notify their supervisor as soon as they realise the potential for a relative, friend or known acquaintance to be admitted to their clinical work place.

The supervisor will determine the best course of action to limit any potential conflict.

Options to be considered are:

1. The patient is admitted to an alternate inpatient unit. This option must take into consideration the clinical needs of the patient.

2. The staff member works in an alternative area for the period of admission of the known patient. This option requires consultation and agreement with the affected staff member.

3. The staff member remains working in the same clinical environment as the patient but not caring directly for the patient. This option requires consultation with both patient and staff member and only allowed if deemed safe and appropriate by management and at management's discretion.

Procedure

1. Staff member and/or patient are to disclose to the person in charge of the clinical area that a potential conflict exists because of the following relationship: relative, friend or known acquaintance.upervisor discusses and considers the most practical solution with regard to the principles and options outlined above. Involving management and/or patient advocate in complex or sensitive matters.

2. As soon as practical, inform the staff member and the patient of the solution and make plans to implement the preferred option.

Principle of Necessity

It is acknowledged that in emergency circumstances some staff might find themselves in a situation where they are treating a relative, friend or acquaintance. Treatment and care should proceed as normal and until the emergency is over and the situation stable. As soon as the staff member is able to inform their senior person at the situation of the relationship, efforts then need to be made to separate the staff member from the patient in accordance with the procedure outlined in this policy.

All clinical staff are reminded of the following that:

1. they can act as their friend or relative's support and advocate but should avoid becoming involved in their clinical care.

2. they should not access their friend or relative's clinical notes or investigations.

3. Have an obligation included in their annual registration to maintain appropriate codes and standards as indicated by the respective National Boards.

Note well:

In the case of a member of staff who is a doctor -

- they should not be the referring doctor for their friend or relative - referrals to eastern health should come from the patients treating practitioner

- they should not be the treating doctor for their friend or relative

- they should not prescribe for their friend or relative

- they should try not to participate in clinical discussions between their friend or relative and the treating Eastern Health team, unless they are participating by the request of the patient. In this case they should confine themselves to a supportive role.

References/Legislation
Privacy Act
Public Hospital Patient Charter
Northeast Health Wangaratta, Providing Services to Employees Relatives Guideline
AHPRA

Related Policy
Patient Rights and Responsibilities

Policy History
Last reviewed Jul 2012

Dissemination/Education Strategy

To be available to all staff via Eastern Health Objectify.

Policy Upload:

Providing Services to Employees Relative Friend Acquaintance checklist.doc

Keywords - providing provide service services admission relative friend acquaintance staff member inpatient care welfare well being patient family

easternhealth

The Role of the Support Person(s) During Labour

Scope: Eastern Health	**Policy Number:** 2270
Executive Sponsor: ED Acute	**Approving Body:** EH Executive Committee
Policy Status: New	**Policy Developed:** 01-02-2013
Last Review Date: 20-03-2014	**Next Review Date:** 20-03-2017

Purpose:

The purpose of this practice guideline is to inform clinicians throughout Eastern Health of their responsibilities regarding the role of support person(s) who attend a woman during her pregnancy and birth so that care is delivered safely, providing the best outcomes for mother and baby.

Details:

1. Context

See Purpose.

2. Definitions of terms

A support person

- Helps and supports a woman through the physical and emotional challenges of labour and birth.
- Is aware of the woman's philosophy around birth.
- Is a person who acknowledges that clinicians have primary responsibility for the care and safety of mother and baby at all times

A clinician

- For the purpose of this document the word 'EH clinician' refers to any Eastern Health employed midwife, doctor or allied health professional.

3. Name of EH Standard to which Practice Guideline relates

Consumer, Carer and Community Participation standard

4. Processes

Rationale:

Eastern Health encourages a woman to have the support person(s) of their choice during labour and birth, to provide continuous support. This support has been shown to be extremely beneficial for the woman. A support person(s) may include independent practicing midwives and doulas.

Women who receive one to one continuous support in labour are more likely to experience a spontaneous vaginal birth, a reduction in intrapartum analgesia, reduction in length of labour and be overall more satisfied with their birth experience[2].

It is important that clear roles are defined, regarding support person(s) and primary health care providers, to allow a woman's care to be managed in a safe and respectful manner which is in line with Eastern Health values, guidelines and policies.

Protocol/Procedure:

Where the woman is involving an independent practising midwife or doula in her care, this policy will be discussed and made available during the antenatal period with the woman, her family and support person(s).

When a woman is accompanied by an independent practicing midwife or doula, it is made clear that this person(s) role is as a support person and not as a professional providing midwifery care.

EH clinicians have primary responsibility for the care and safety of both mother and baby at all times.

EH clinicians may require that a support person(s) leave the birthing room or hospital whenever deemed necessary to facilitate care to the woman. If the support person interferes with safe care, the clinician may require that they leave.

Where an EH clinician has a pre-existing relationship with the woman, it must be made clear what their role is – either clinician or support person.

If any EH clinician accompanies a woman as her support person when off duty, they must be made fully aware that they will not carry any primary responsibilities for the care and safety of the mother and her baby and will assume the role of a support person only.

It is the responsibility of all clinicians to be familiar with, and follow all EH Clinical Practice Guidelines, to ensure that this guideline where relevant, is discussed and made available to women and their families who access the Eastern Health's Maternity Services.

Clinicians who feel that they have a conflict of interest should be relieved of their professional duty at the earliest opportunity.

Any EH clinician, who has a pre existing non professional relationship with a woman such as being a relative or friend, should consider not being involved professionally in the clinical care or management of the woman. The woman should be advised of the potential conflict of interest if this clinician consults with her on a professional level. She should be advised to seek out care from other healthcare professionals [1]. If there is any doubt, consultation should occur with the manager/senior clinician and care should be transferred to another clinician.

Clinicians have a responsibility to maintain professional boundaries between themselves and each woman and infant in their care [5 & 6].

5. Roles, Responsibilities & Behaviour

Staff Group	Roles and Responsibilities
CEO	Ensure standard and CPG is in place
Executive Directors (including professional officers)	Ensure standard and CPG is in place and that they are effectively implemented
Executive Clinical Directors	Ensure standard and CPG is in place, that they are effectively implemented, participate in review of CPG
Clinical Directors	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program, participate in review of CPG
Head of Unit	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program, participate in review of CPG
Directors, Program Directors, Associate Program Directors	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program/s Coordinating author, participate in review of CPG, support staff in review and development of CPG, ensure measures are in place to review CPG
Department/Unit Managers	Knowledge of guideline. Ensure clinicians implement the CPG, provide support to frontline staff, participate in review and development of CPG
Front line service delivery and support staff	Knowledge of guideline, implementation of CPG, participate in review and development of CPG
Consumer / Carer	To understand the process, as described by the clinicians implementing this CPG

6. Skills, Knowledge & Competencies

Staff Group	Skills, Knowledge Competency Required	Training Required	Delivery Mechanism	Responsibility	Timeframe
Women and Children staff - maternity	CPG processes How to access Objectify	Reading and understanding the CPG Knowledge of how to use Objectify	Online, memo, communication via EH Weekly – updates of new and updated CPGs	Adhere to CPG	For new clinicians, following orientation to ED or W&C Program
Maternity clinicians	Individuals to have an understanding and knowledge of professional codes of conduct	AHPRA registration	AHPRA	Individual clinicians knowledge	Ongoing

7. Tools & Techniques

- Objectify
- Clinical Practice Guideline
- Code of professional conduct for Midwives in Australia
- Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia

8. Measures

Measure	Target	Date Target Due	Frequency of measurement	Person (role) responsible for collection	Person (role) accountable for target	Reporting line (committee)
Staff acting as a support person in labour are aware of the guideline and discuss with their manager prior to labour	100%	Ongoing	Annually	Midwifery Managers, Director O&G Angliss and Box Hill	APD W&C	W&C Program, Quality and Strategy, Clinical Review and Performance Committee

9. Practice Guideline Risk Rating

What may potentially happen if the Consumer, Carer and Community Participation standard is breached or standard not achieved using EH Risk Tables and Matrix .	Consequence Rating	Likelihood Rating	Risk Rating
Potential harm to mothers and babies where there is a conflict of interest	Extreme	Remote	Moderate

10. References

1.Australian Nursing & Midwifery Council (ANMC). Code of Professional Conduct for Midwives in Australia: Professional Practice Framework 2008.

2. Hodnett E.D, Gate S, Hofmeyer G. J, Sakala C. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews. 2007.

3. The Royal Women's Hospital, Melbourne. Support persons: birth and caesarean birth. Policy and Procedure Manual 2006.

4. The Mercy Hospital for Women. Support Persons in Birth Suites/Family Birth Centre. Policy. 2009

5. Australian Nursing and Midwifery Council (ANMAC), February 2010, A Midwife's Guide to Professional Boundaries. http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx

6. Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

11. Development History

Developed Feb 2013, Reviewed 20/3/2014.

Update only to existing CPG, linked to Intrapartum care for Normal Birth and Expected Pathways of Care for Pregnant Women CPGs March 2014

Attachment 1 Role of the Support Person in Labour - information sheet was approved at the August W&C Q&S meeting and uploaded October 2014

12. Attachment

Role of the Support Person In Labour - Information Sheet

Additional Documents:

2270 Role of the Support Person(s) Attachment 1.pdf

Keywords - Suuport in Labour support person intrapartum labour care

easternhealth
GREAT HEALTH AND WELLBEING

Eastern Health Practice Guideline

Title

Prelabour Rupture of Membranes at Term

Performance Standard Sponsorship

Executive Sponsor	Title	Executive Director Acute Health
	Name	David Plunkett
Director Sponsor	Title	Program Director Women and Children
	Name	Lisa Lynch
Coordinating Author	Title	Executive Clinical Director Women and Children
	Name	Malcolm Barnett
	Contact number	9895 3379

Commissioning

Is this practice guideline new	Yes ☐ No x☐ Date first developed 1.3.10	Continue with Commissioning steps Proceed to development / review section
Purpose of new practice guideline	To guide appropriate management of women with prelabour rupture of membranes at term	
Strategic Direction (select best fit)	Strategic Direction 1 - A Provider of Great Healthcare ☐ Strategic Direction 2 - A Great Patient Experience ☐ Strategic Direction 3 - A Great Place to Learn & Work ☐ Strategic Direction 4 - A Great Partner with our Communities ☐ Strategic Direction 5 - A Great Achiever in Sustainability ☐	
Have you considered relevant: Legislation ☐ External benchmarks ☐ External standards ☐ Risk Register Item ☐ Other ☐ Details		
Are there existing performance standards relevant to this topic?	Yes ☐ Detail No ☐	
Which standard would this practice guideline align to?		

Commissioning sponsor approval to develop Performance Standard (*Completed by Sponsor noted above*)		
Will this new performance standard help EH achieve a desired outcome?	Yes ☐	No ☐
Is the proposed policy alignment the best fit?	Yes ☐	No ☐
Have resource requirements for the development and implementation of this new performance standard been considered / allocated	Yes ☐	No ☐
Approval to proceed with development Date Commissioned: Reason (if No)	Yes ☐ Priority for Development 1 ☐ 2 ☐ 3 ☐	No ☐

Development / Review

Scope of Practice Guideline	Clinical Guideline / Drug Protocol EH Wide ☐ Program specific x☐ Directorate specific ☐	Professional Guideline ☐	Corporate Procedure ☐
Date review commenced	January 2014		
Key external information sources consulted: Legislation ☐ External benchmarks ☐ External standards x☐ Risk Register Item ☐ Other ☐ Details			
Key Stakeholders consulted in development / review *eg. IPAC, OH&S, Support Services, ICT, Residential Care, Corporate Counsel.*	Name Maternity and Gynaecology CPG Committee	Title	
Implementation plan developed and attached?	Yes – Performance standard is new or significantly revised ☐ No – Performance standard has undergone only a minor revision ☐		
Performance standards to be removed following approval	Document Numbers & Titles		
Further comments/ notes			
Key search words	PROM, ROM, rupture of membranes, SROM,		

Title

Prelabour Rupture of Membranes at Term

1. Context

Term Prelabour Rupture of Membranes occurs in about 8% of Maternity patients. This guideline is designed to guide appropriate management of this condition.

2. Definitions of terms

Term Prelabour Rupture of membranes (Term PROM) Is defined as rupture of the membranes proper to the onset of labour at or beyond 37 weeks gestation.(1)

Abbreviations:
CTG: Cardiotocograph
GBS: Group B Streptococcus
IOL: Induction of Labour
PROM: Prelabour Rupture of Membranes

3. Name of EH Standard to which Practice Guideline relates

Appropriate and effective clinical care

4. Processes

The development of this guideline has been assisted by other guidelines, including, but not limited to South Australia Health Department(16), Queensland Health(25), King Edward Memorial Hospital Perth(21), National ~~Maternity Hospital~~ Womens Health Auckland City Hospital (23), Mercy Hospital Melbourne, Southern Health (now Monash Health), and NICE(8) guidelines.

4.1 Background

In approximately 8% of pregnancies at term the fetal membranes rupture before labour begins. Following Term PROM 60% of women will labour spontaneously within 24hours and over 91% within 48 hours, 6% remain pregnant beyond 96 hours(2) The short-term risks of rupture of membranes are uncommon and include cord prolapse, cord compression and placental abruption. Risks of delayed delivery include maternal and neonatal infection. Active management of term PROM with induction of labour is associated with a lower risk of maternal infective morbidity without increasing caesarean section or operative vaginal birth. Fewer infants are admitted to NICU and fewer infants require postnatal antibiotics.(3) Nevertheless, a short period (up to about 24 hours) of expectant management may be considered (following preliminary assessment) at the patient's or clinician's discretion in well selected and supervised cases.

4.2 Assessment

Initial assessment of women presenting with Term PROM should include

- Confirmation of the diagnosis
- Confirmation of gestation and presentation
- Assessment of maternal and fetal wellbeing (including vital signs, abdominal palpation and CTG).

Digital vaginal examination should be avoided unless immediate induction is planned as this has been shown to increase the rate of neonatal infection.

4.2.a Speculum Examination

The speculum (lubricated with a sterile water-soluble lubricant) should not touch the cervix. The cervical dilatation and the presence or absence of a prolapsed umbilical cord should be noted. If there is any suspicion of sepsis, two swabs are taken from the cervix - one air-dried on a glass slide for Gram stain, and the other placed in a transport culture medium. If amniotic fluid is obviously draining from the cervix, no further action regarding confirming PROM needs to be taken. Nitrazine (pH based) tests or Amnisure (detecting placental alpha microglobulin-1protein in vaginal fluid) may be used where there is diagnostic uncertainty.If there is no amniotic fluid visible, the patient can be discharged from hospital unless there is strong clinical suspicion of the diagnosis.
All non-cephalic presentations presenting with ruptured membranes at term must have a digital vaginal examination to exclude cord prolapse after discussion with a level 3 clinician

4.2.b Ultrasound Examination

An ultrasound examination may be a useful adjunct to diagnosis (an amniotic fluid index of 5 or more suggests that there is no PROM). Ultrasound examination showing a markedly reduced amniotic fluid volume in the presence of normal fetal kidneys and the absence of IUGR is highly suggestive of ruptured membranes, however normal amniotic fluid volume does not exclude the diagnosis.

4.3 No Evidence of Rupture of Membranes:

If there is no definitive evidence of PROM and no other risk factors, the woman can be discharged home.

4.4 Un-confirmed Rupture of Membranes:

If the diagnosis of PROM is in doubt, repeat the speculum examination, after a period of two hours lying down. The use of Amnicator ® swabs does not provide more accurate diagnosis than visualising amniotic fluid passing through the cervix. Amnicators may give false positives with alkaline vaginal discharge (bacterial vaginosis), semen and or blood.

In the event of the diagnosis of rupture of membranes being uncertain in either the presence of a cervical suture or known group B streptococcus carrier, a woman should not be discharged from hospital without review by a level 2 or 3 clinician

4.5 Confirmed Rupture of membranes::

Women with Term PROM who are not in labour need to be fully informed of the risks and benefits of both active and expectant management options. Their preferences should be acknowledged and considered when making collaborative decisions about their suitability for either form of management and where that management should take place. Women should be advised that Chorioamnionitis may be asymptomatic and may carry risks to the baby.

4.6. Criteria for early induction through active management

Increased risk of infection including history of

- cervical suture
- digital examination
- GBS positive status (see below)

Any clinical evidence of infection, including the presence of

- fever
- maternal tachycardia
- uterine tenderness
- offensive loss

Increased risk of fetal compromise including

- antenatal complications
- oligohydramnios prior to SROM
- discoloured or offensive liquor
- abnormal CTG
- decreased fetal movements

4.6.1 GBS positive

Women who are identified as

- GBS positive on low vaginal swab
- GBS positive bacteriuria at any time during the pregnancy
- having a previously GBS infected baby (despite current status)
- who have been designated antenatally as "treat as GBS Positive" by clinician and not screened

should have induction of labour with antibiotic prophylaxis recommended if they are not contracting to reduce the incidence of neonatal infection [10 11 12]. This should be as soon as staffing and bed availability ensures it is safe to do so. If this occurs during the night, the obstetric registrar and midwifery AUM should determine the most appropriate time for starting induction. Antibiotic coverage intravenously should not be delayed. (Refer to Maternal Group B Streptococcus in Pregnancy: Screening and Management CPG

4..6.2 GBS status is unknown

Where GBS status is unknown, an estimated 10-30% of women will have vaginal carriage of this organism [9]. Increased risk of early onset GBS sepsis is associated with gestations of <37 weeks, where ROM > 18 hrs or maternal fever is present[11]. A risk assessment is undertaken of the GBS unknown woman and management guided by this. Please refer to Prevention of Neonatal Group B Streptococcus Clinical Practice Guideline (inset hyperlink)

4..7 Patient/clinician request

The woman's or clinicians request should be taken into consideration where there is the facility to accommodate her safely for immediate induction (ie staffing, time of day, occupancy).

4.8 Criteria for expectant management:

- Singleton pregnancy
- Term PROM with fixed cephalic presentation
- GBS negative
- No signs of infection(maternal tachycardia, fever, uterine ternderness)
- Normal reactive CTG
- No history of digital vaginal examination, cervical suture

- Clear or pink liquor
- Green Pathway
  AND the woman wishes to await labour onset (either in hospital or at home) after discussion of the risks and benefits outlined above.

4.9 Expectant Management

4.9.1 Timing of IOL

In the absence of complications and having met the above criteria the woman may be offered the choice of awaiting the onset of labour for a period of 24hrs. The risk of neonatal infection increases in a linear fashion with increasing latency from PROM. In one large study the risk of neonatal sepsis was 0.3% at 0-6 hours, 0.5% at 6-18 hours, 0.8% at 18-24 hours and 1.1% after 24 hours(26). For this reason, induction of labour should ideally be commenced within about 24 hours of ROM.
Booking for induction of labour should be made in collaboration with Birthing Suite.
Some women may choose to continue expectant management beyond 24 hours, and their decision should be respected. Continuing surveillance and regular review is to be recommended. Women should be advised that Chorioamnionitis may be asymptomatic and may carry risks to the baby.

4.9.2 Role of antibiotics

The available evidence suggests that the GBS negative woman does not require antibiotic therapy until they have had ROM >18hrs provided they remain afebrile[10]., Antibiotic therapy for prolonged ruptured membranes (>18 hrs) is thought to reduce the risk of infection, and should be commenced in the oral form (Ampicillin/Amoxycillin 500mg QID) while awaiting labour onset and continued in the IV form (Ampicillin/Amoxycillin 1g QID) when in active labour. Broader antibiotic cover is required in the presence of suspected/confirmed infection

4.9.3 Surveillance during expectant management

The following observations are recommended while awaiting labour onset:

- 4th hourly oral temperature (during waking hours)
- 4th hourly pad checks for discoloured or offensive vaginal loss
- 4th hourly fetal movements and fetal heart rate (if hospitalised).

4.10 Location: Home or Hospital?

The implications of location, for expectant management (i.e. home or hospital) has not been the primary focus of any specific research. Much of the available information is based on secondary analysis of data from 1670 women randomised to the expectant management group in the later part of the term PROM trial (Jan 1994 – May 1995), which confirmed an increase in perinatal infection (27).

Some women will request to return home while awaiting the onset of labour. Regardless of the location of expectant management, attention needs to be given to appropriate surveillance with respect to the potential for infection.

The decision relating to the best location for expectant management needs to be made on a case by case basis, collaboratively involving the Registrar, Consultant and Senior Midwife of the day.

4.11 Specific instructions for expectant management at home

If considered appropriate for the option of home care while awaiting labour onset, the following instructions are to be discussed:

- 4th hourly (during waking hours) maternal oral temperatures to exclude infection should be advised and initiated.
- Detailed written instructions about reporting any evidence of fever, discolouration or offensive odour of the amniotic fluid, or reduced fetal movements. This will be available in a range of languages and include important contact numbers (See Appendix 1).
- A chart will be provided for documentation of the temperature, vaginal loss and fetal movements.
- Booking for induction of labour should be made in collaboration with the Birthing Suite within a 24 hour timeframe, should spontaneous onset not occur. Documentation of the booked admission date and time to be included within the written information for women.
- Where the induction booking is scheduled between 18-24 post ROM hours it is advisable that the woman return for clinical assessment at approx 18 hrs, and antibiotics commenced. The development of any of the previously described 'risks for presence of infection or fetal compromise' at the time of review are indications for immediate induction.
- Women should be informed that ~~bathing or~~ showering is~~are~~ not associated with an increase in infection, but that bathing or having sexual intercourse may be[8].

4.12 Active Management:

- Oxytocin rather than vaginal prostaglandins is preferred for the induction of labour in the presence of term PROM.

- Induction of labour with vaginal prostaglandins is associated with an increased risk of chorioamnionitis and neonatal infection in comparison with an oxytocin induction and is not recommended.
- Continuous CTG monitoring is indicated (14)

4.13 If there is evidence of infection:

- A full course of broad spectrum antibiotics should be admnistered as soon as possible but definitely within 3 hours of diagnosis of sepsis (11, 13)and delivery facilitated, either by immediate induction of labour or caesarean section, depending on the clinical circumstance
- Take blood cultures and serum lactate levels prior to commencement of antibiotics (11, 12)

4.14 Post natal care:

- Asymptomatic term babies born to women with prelabour rupture of the membranes (more than 24 hours before labour) should be closely observed for the first 12 hours of life (at 1 hour, 2 hours and then 2-hourly for 10 hours)(15)
- These observations should include:
    - general wellbeing
    - chest movements and nasal flare
    - skin colour including perfusion, by testing capillary refill
    - feeding
    - muscle tone
    - temperatureheart rate and respiration[8]
- A baby with any symptom of possible sepsis, or born to a woman who has evidence of chorio-amnionitis, should immediately be referred to a paediatrician (1, 6, 7,8).

- **Related Policy:**
- Maternal Group B Streptococcus in Pregnancy: Screening and Management
- Intrapartum Fetal Surveillance and CTG Interpretation
- Victorian Standards for Induction of Labour

5. Roles, Responsibilities & Behaviour

Staff Group	Roles and Responsibilities
CEO	Ensure standard and CPG is in place
Executive Directors (including professional officers)	Ensure standard and CPG is in place and that they are effectively implemented
Executive Clinical Directors	Ensure standard and CPG is in place, that they are effectively implemented, participate in review of CPG
Clinical Directors	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program, participate in review of CPG
Head of Unit	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program, participate in review of CPG
Directors, Program Directors, Associate Program Directors	Knowledge of guideline, ensure implementation of the CPG by clinicians across the Program/s Coordinating author, participate in review of CPG, support staff in review and development of CPG, ensure measures are in place to review CPG
Department/Unit Managers	Knowledge of guideline. Ensure clinicians implement the CPG, provide support to

Staff Group	Roles and Responsibilities
	frontline staff, participate in review and development of CPG
Front line service delivery and support staff	Knowledge of guideline, implementation of CPG, participate in review and development of CPG
Consumer / Carer	To understand the process, as described by the clinicians implementing this CPG

6. Skills, Knowledge & Competencies

Staff Group	Skills, Knowledge Competency Required	Training Required	Delivery Mechanism	Responsibility	Timeframe
Maternity staff	CPG processes How to access Objectify	Reading and understanding the CPG Knowledge of how to use Objectify	Online, memo, communication via EH Weekly – updates of new and updated CPGs Presentation at Combined Perinatal Review Meeting	Adhere to CPG	For new clinicians, following orientation to ED or W&C Program
Women with Term PROM	Understanding information provided by EH	Discussion with clinicians providing maternity care	Face to face discussion, information sheet	Read information provided Ask questions if needed	Ongoing

7. Tools & Techniques

- CPG/Objectify
- Education forums
- Team meetings – unit, Perinatal Review
- EH communication channels

8. Measures

Measure	Target	Date Target Due	Frequency of measurement	Person (role) responsible for collection	Person (role) accountable for target	Reporting line (committee)
Intrapartum documentation audit	100%	ongoing	annual	Maternity data collection manager	Midwifery Managers HOU	W&C Clinical Review, Performance and Monitoring Standards Commitee

9. Level of Supporting Evidence Available

10. Practice Guideline Risk Rating

What may potentially happen if the <Insert standard name> is breached or standard not achieved using EH Risk Tables and Matrix .	Consequence Rating	Likelihood Rating	Risk Rating
Potential harm to mothers and babies	Catastrophic	Occasional	High

11. References

1. 1.NICE clinical guideline: Induction of labour. 2008
2. 2.Savitz DA et al.(1997). Influence of gestational age on the time from spontaneousrupture of the chorioamniotic membranes to the onset of labor.AmJ Perinatol 14: 129 33
3. Dare MR, Middleton P, Crowther CA, Flenady V, Varatharaju B. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). Cochrane Database of Systematic Reviews 2006, Issue 1. Art. No.: CD005302. DOI: 10.1002/14651858.CD005302.pub2.
4. 4.The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. College Statement C-Obs 36. Term Prelabour Rupture of membranes. July 2010. Avail at http://www.ranzcog.edu.au/publications/

Prelabour Rupture of the Membranes at Term Clinical Guidelines King Edward Memorial Hospital Perth Western Australia Date Revised: August 2011 http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/2/5172.pdf ~~5.~~ Accessed 23 Feb 2014

6. 6.Hannah ME, Ohlsson A, Farine D et al. Induction of labour compared with expectant management for prelabour rupture of the membranes at term. TERMPROM Study Group. NEJM 1996 Apr 18; 334 (16): 1005-10.
7. Victorian Standard for Induction ofLabour Maternity & Newborn Clinical Network

~~8.~~ http://docs.health.vic.gov.au/docs/doc/DAFDE586691FE06FCA2579880003C769/$FILE/victorian_standard_for_induction_of_labour.pdf

~~9.~~8. NICE clinical guideline 55; Intrapartum care: Care of healthy women and their babies during childbirth Issued: September 2007

~~10.~~9. guidance.nice.org.uk/cg55; accredited by NHS Evidence September 2009 http://guidance.nice.org.uk/CG55/NICEGuidance/pdf/English

~~11.~~10. 9. Three Centres Concensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's and Children's Health, 2001. Melbourne.

~~12.~~11. 10. Centres for Disease Control and Prevention. Prevention of Perinatal Group B Streptococcal Disease. MMWR 2002;51 (No. RR-11)

~~13.~~12. Munro. J, Spiby.J, (2000) *Evidence Based Midwifery: Guidelines for midwifery led care in labour.* The Central Sheffield University Hospitals. UK Royal College of Obstetricians & Gynaecologists (RCOG). (2001). *Clinical guideline-Induction of labour* (No. 9). London.

~~14.~~13. 13.Mozurkewich, E [1999] Management of premature rupture of membranes at term: an evidence-based approach. *Clinical Obstet and Gynaecol.* 42 [4]: 749

~~15.~~14. 14.Enkin. M, Keirse. M.J.N.C, Neilson. J, Crowther. C, Duley.L, Hodnett.E, Hoffmeyr. J. (2000) *A guide to effective care in pregnancy and childbirth.* 3rd Edition. Oxford University Press. Oxford. UK.

~~16.~~15. 15.Mozurkewich, E [1999] Management of premature rupture of membranes at term: an evidence-based approach. *Clinical Obstet and Gynaecol.* 42 [4]: 749

~~17.~~16. South Australia Health Department Guideline http://www.sahealth.sa.gov.au/wps/wcm/connect/f3f6dd004eed8eb6afefaf6a7ac0d6e4/Pre-labour-rupture-membranes-37weeks-WCHN-PPG-18052010.pdf?MOD=AJPERES&CACHEID=f3f6dd004eed8eb6afefaf6a7ac0d6e4

~~18.~~17. Uptodate Term PROM Guideline

~~19.~~ http://www.uptodate.com/contents/management-of-premature-rupture-of-the-fetal-membranes-at-term (accessed May 2014)

~~20.~~18. RANZCOG www.ranzcog.edu.au/doc/**term-prom**.html (Accessed May 2014)

~~21.~~19. Ontario midwives Guideline on Term PROM

~~22.~~ http://www.ontariomidwives.ca/images/uploads/guidelines/No13CPG_PROM_final.pdf (accessed June 2014)

~~23.~~20. ~~20.~~ Royal Cornwall Hospitals

~~24.~~ http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/MidwiferyAndObstetrics/RuptureOfMmembranesAtTermTermPROMGuidelineOnTheManagementOfPreLabour.pdf (accessed May 2014)

~~25.~~21. ~~21~~. King Edward Memorial Hospital Perth

~~26.~~ http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/2/5172.pdf (Accessed May 2014)

~~27.~~22. ~~22.~~ WHO (RHL Library)

~~28.~~ http://apps.who.int/rhl/pregnancy_childbirth/complications/prom/bscom/en/ (Accessed May 2014)

~~29.~~23. ~~23~~. National Womens Hospital Auckland New Zealand

~~30.~~ http://nationalwomenshealth.adhb.govt.nz/Portals/0/Documents/Policies/Rupture%20of%20Membranes_.pdf (accessed May 2014)

~~31.~~24. ~~24.~~ Department of Health Maternal and Child Network Victoria Guideline

~~32.~~ http://docs.health.vic.gov.au/docs/doc/DAFDE586691FE06FCA2579880003C769/$FILE/victorian_standard_for_induction_of_labour.pdf (accessed May 2014)

25. ~~25~~. Queensland Maternity and Neonatal Clinical Guideline: Induction of Labour, 2011, Ammendment 2014.

26. Herbst A, Källén K Time between membrane rupture and delivery and septicemia in term neonates. Obstet Gynecol. 2007;110(3):612.

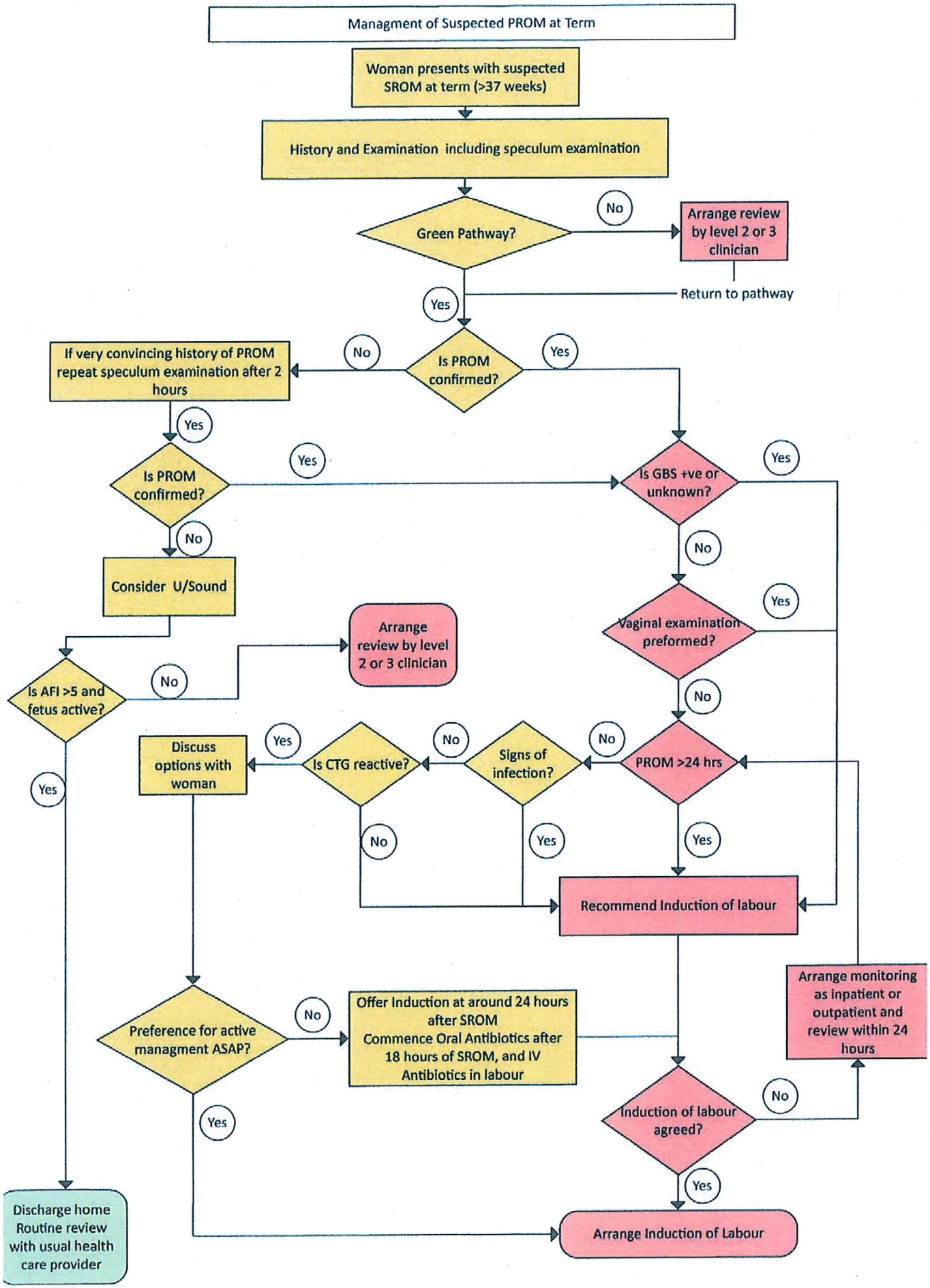
27. Hannah ME, Hodnett ED, Willan A, Foster GA, Di Cecco R, Helewa M Prelabor rupture of the membranes at term: expectant management at home or in hospital? The TermPROM Study Group Obstet Gynecol. 2000;96(4):533.

~~33.~~28.

12. Development History

Rupture of Membranes – Pre-Labour / Pre-Term (PROM) – Eastern Health Policy Number 1871(unpublished 8/6/2010).
Algorithm: Term Pre Labour Rupture of Membranes approved at EH W & C Quality & Strategy 20 September 2012 August 2013 – Reviewed by relevant Executive Director to ensure compliance with standards and current legislation and is reflective of current practice. Further review required in 12 months.
3/12/2013 - Addition of Consumer Handout - Term Pre Labour Rupture of Membranes (PROM) Attachment 2.
Revised February 2014

13. Attachments


Managment of Suspected PROM at Term
Woman presents with suspected SROM at term (>37 weeks)
History and Examination including speculum examination
Green Pathway?
No
Arrange review by level 2 or 3 clinician
Return to pathway
Yes
Is PROM confirmed?
No
Yes
If very convincing history of PROM repeat speculum examination after 2 hours
Yes
Is PROM confirmed?
Yes
No
Consider U/Sound
Is AFI >5 and fetus active?
No
Arrange review by level 2 or 3 clinician
Yes
Is GBS +ve or unknown?
Yes
No
Vaginal examination preformed?
Yes
No
PROM >24 hrs
No
Signs of infection?
No
Is CTG reactive?
Yes
Discuss options with woman
Yes
No
Yes
Yes
Recommend Induction of labour
Arrange monitoring as inpatient or outpatient and review within 24 hours
Preference for active managment ASAP?
No
Offer Induction at around 24 hours after SROM
Commence Oral Antibiotics after 18 hours of SROM, and IV Antibiotics in labour
Induction of labour agreed?
No
Yes
Yes
Discharge home
Routine review with usual health care provider
Arrange Induction of Labour

Endorsement and Approval

Confirmation of Practice Guideline Scope		
Clinical Guideline / Drug Protocol EH Wide ☐ Program specific ☐ Directorate specific ☐	Professional Guideline ☐	Corporate Procedure ☐
Director Sponsor		
Associate Director QPI		

Endorsement by relevant committee			
Name(s) of Endorsing Committee(s) *e.g. Quality & Strategy committee, Expert Advisory Committee as appropriate to scope of performance standard.*	Conditions of endorsement	Date Endorsed	Please notify coordinating author of endorsement and relevant conditions

Approval by relevant committee			
Performance Standard approved for		1 Year only (Risk rating = Extreme) ☐ 2 Years only (Risk rating = High) ☐ 3 Years only (Risk rating = Moderate or Low) ☐	
Alignment of Practice Guideline		Include date approved	
EH Wide *i.e.relevant/applicable to staff across more than one directorate*	Clinical Executive Committee	☐	Please notify coordinating author and Policy system manager
Program or Directorate specific	Program / Directorate Quality & Strategy Committee *Specify*	☐	
Professional Practice Guideline	Professional Council *Specify*	☐	
Corporate Procedure	Corporate Quality & Strategy Committee	☐	

Publishing

Date performance standard approval notified to policy system manager	
Date performance standard forwarded to policy administrator	
Date performance standard published on Objectify	